

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/25/2011	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Recertification State Licensure Survey completed on 9-6-11. This visit included the PSR to the Complaint IN00094314 completed on 9-6-11.</p> <p>Complaint IN00094314- Corrected.</p> <p>Surveyor Dates: October 24, 25, 2011</p> <p>Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130</p> <p>Survey Team: Patti Allen, BSW, TC Marcy Smith, RN Barbara Hughes, RN Karina Gates, Medical Surveyor Elizabeth Kolasa, RN (October 25, 2011)</p> <p>Census Bed Type: SNF/NF: 112 Total: 112</p> <p>Census Payor Type: Medicare: 22 Medicaid: 71 Other: 19 Total: 112</p> <p>Sample: 14</p> <p>Kindred Transitional Care of Castleton was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2. in regard to the Post Survey Revisit to the Recertification and State</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 Licensure Survey and Complaint IN00094314. Quality review completed on October 28, 2011 by Bev Faulkner, RN	{F 000}			